Washington State Department of Health

Rabies Post-Exposure Prophylaxis (PEP)

County

LHJ Use ID _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed** ☐ **Probable**
By: ☐ **Lab** ☐ **Clinical** ☐ **Epi Link:** _____

☐ **Outbreak-related**
LHJ Cluster# _____
LHJ Cluster Name: _____
DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation start date: ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Zip code (school or occupation): _____ Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy Place of death _____

Vaccination

Y	N	DK	NA	
☐	☐	☐	☐	Patient ever received rabies containing vaccine

Number of doses prior to exposure: ____
Dose 1 Date received: ___/___/___
Dose 2 Date received: ___/___/___
Dose 3 Date received: ___/___/___
Dose 4 Date received: ___/___/___
Dose 5 Date received: ___/___/___

☐	☐	☐	☐	Patient completed rabies vaccine series in past (at least 3 doses)
☐	☐	☐	☐	Tetanus vaccine in the last 5 years

Date of last tetanus dose: ___/___/___

Laboratory

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

Collection date ___/___/___

P	N	I	O	NT	
☐	☐	☐	☐	☐	Animal rabies testing

Date animal submitted for testing: ___/___/___
Results expected date: ___/___/___
Lab submitted to: _____

NOTES

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

EXPOSURE

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Destinations/Dates: _____
_____

Y N DK NA

☐ ☐ ☐ ☐ Animal exposure
Type of animal exposure:
☐ Bite ☐ Saliva ☐ Scratch
☐ Bat in house ☐ Bat in sleeping area
☐ Other: _____ ☐ Unk
Type of animal:
☐ Bat ☐ Cat ☐ Dog ☐ Ferret ☐ Raccoon
☐ Other: _____ ☐ Unk
Animal status:
☐ Domestic ☐ Stray ☐ Wild
☐ Other: _____ ☐ Unk
Animal description: _____
Breed: _____
Animal name: _____

Y N DK NA

☐ ☐ ☐ ☐ Injury or exposure circumstances known
Date of exposure: ___/___/___
Exposure location: _____
Anatomic site of injury or wound (e.g., head, arm):_____
Circumstances of animal exposure: _____
_____
Wound cleaned: ☐Y ☐N ☐DK ☐NA
Animal exposure provoked ☐Y ☐N ☐DK ☐NA
Others exposed to animal ☐Y ☐N ☐DK ☐NA

Y N DK NA

☐ ☐ ☐ ☐ Animal vaccination history known
Animal rabies vaccination status:
☐ Unvaccinated or vaccine not current
☐ Vaccinated ☐ Unk
Date of (animal) last rabies vaccine: ___/___/___
Total # (animal) rabies doses: _____

Y N DK NA

☐ ☐ ☐ ☐ Animal contact/control information known
Animal owner or location (e.g. park) name: _____
_____
Owner or location address: _____
_____
Owner or location phone number: _____
Veterinary clinic name: _____
Clinic address: _____
Clinic phone: _____
Veterinarian name: _____
Animal control contact name: _____
Animal control contact phone: _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

Exposure details: _____

☐ **No risk factors or exposures could be identified**
☐ **Patient could not be interviewed**

PATIENT PROPHYLAXIS / TREATMENT

Y N DK NA

☐ ☐ ☐ ☐ Human RIG given
Date: ____/____/____
Prescribing health care provider: _____
_____
Phone: _____
☐ RIG refused (complete refusal form)

☐ ☐ ☐ ☐ Rabies vaccine given
Date of initial vaccination: ____/____/____
Vaccine name: _____
Prescribing health care provider: _____
Phone: _____
☐ Vaccination refused

☐ ☐ ☐ ☐ Did case receive full series of PEP?
If not, reason:
☐ Animal tested negative for rabies
☐ Other, specify: _____

Recommendations

Y N DK NA

☐ ☐ ☐ ☐ PEP recommended
Weight: _____

Determined by:
LHJ _____
DOH _____
HCP _____

Referral for follow-up:
LHJ _____
DOH _____
HCP _____

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Public health actions

PUBLIC HEALTH ACTIONS

Animal disposition: ☐ Sent for testing ☐ Under observation
☐ Healthy after 10 day observation
☐ Lost to follow-up ☐Other: _____
Quarantine site contact name: _____
Quarantine site address: _____
Quarantine site phone: _____

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___
Local health jurisdiction _____ **Record complete date** ____/____/____

Rabies PEP: case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered